TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
MICHAEL CASTRO, MD

MFDR Tracking Number
M4-18-0069-01

MFDR Date Received
September 07, 2017

Respondent Name
ACCIDENT FUND GENERAL INSURANCE

Carrier's Austin Representative
Box Number 06

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization of services was requested from our office and approved by the insurance carrier (copy of preauthorization letter has been included in this reconsideration request for reference)."

Amount in Dispute: $1,007.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The dispute has been reviewed by the carrier with its audit company. It is the carrier's position at this time that the bills at issue were correctly audited."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 30, 2017 through July 27, 2017	97140	$1,007.64	$449.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 247- A payment or denial has already been recommended for this service
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services

Issues

1. Did the requestor obtain preauthorization for the disputed physical therapy services?
2. What are the Medicare payment polices that apply to physical therapy services?
3. What rules apply to determine the MAR?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The requestor billed for CPT Code 97140-GP rendered on May 30, 2017 through July 27, 2017. The insurance carrier states in pertinent part, "It is the carrier's position at this time that the bills at issue were correctly audited." The requestor states in pertinent part, "Preauthorization of services was requested from our office and approved by the insurance carrier..."

   The insurance carrier denied the disputed services with denial reduction codes "247, B13, 119 and 168", (explanation for the reduction codes are noted above).

   28 Texas Administrative Code §134.600(p) (5) states in pertinent part, "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning..."

   Review of the preauthorization letter dated July 17, 2017 finds the following:

Requested Service Description	Certified Quantity	Start Date	End Date	Outcome
Physical therapy 3 x wk x 4 wks CPT Codes: 97110, 97530 and 97140	12 Physical Therapy	05/24/2017	10/31/2017	"On behalf of Accident Fund, the requested treatment/service referenced above has been reviewed by Coventry Health Care Workers' Compensation, Inc. (Coventry), and has been determined to be medically necessary."

   Review of the preauthorization letter dated June 8, 2017 finds the following:

Requested Service Description	Certified Quantity	Start Date	End Date	Outcome
Physical therapy 3 x wk x 4 wks CPT Codes: 97110, 97530 and 97140	12 Physical Therapy	05/24/2017	07/21/17	"On behalf of Accident Fund, the requested treatment/service referenced above has been reviewed by Coventry Health Care Workers' Compensation, Inc. (Coventry), and has been determined to be medically necessary."

   The Division finds that the requestor obtained preauthorization for the disputed CPT Code 97140 and was rendered within the preauthorized time frames of May 24, 2017 through October 31, 2017. The preauthorization letter did not document or notate a restriction on the number of units to be rendered for each disputed CPT Code. Review of the submitted documentation supports that preauthorization was obtained for the dispute services and rendered within the preauthorized timeframes. As a result, the requestor is entitled to reimbursement for the disputed services.

2. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   To determine reimbursement, the Division applies Medicare's payment policies for physical therapy services. Per MLN Matters® Number: MM7050, with an Implementation Date: January 3, 2011, the following policies apply: **"**Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings... The reduction applies to the HCPCS codes contained on the list of 'always therapy'

services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services... The MPPR applies to the codes on the list of procedures included with CR7050 as Attachment 1. CR7050 is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf.**"

To determine the MAR for the disputed service, CPT Code 97140-GP, this division will calculate the MAR for CPT Code 97110-GP, which is not in dispute and was billed on the same day as CPT Code 97140.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 97110 rendered on May 30, 2017 through July 25, 2017 is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.015 is 0.45675. The practice expense (PE) RVU of 0.45 multiplied by the PE GPCI of 1.012 is 0.4554. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.77 is 0.0154. The sum of 0.92755 is multiplied by the division conversion factor of $57.50 for a MAR of $53.33. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date for dates of service May 20, 2017 through July 25, 2017.

   Procedure code 97140, May 30, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

   Procedure code 97140, June 1, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

   Procedure code 97140, June 5, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

   Procedure code 97140, June 6, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

   Procedure code 97140, June 8, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

   Procedure code 97140, June 12, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

   Procedure code 97140, July 13, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

   Procedure code 97140, July 17, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

Procedure code 97140, July 18, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

Procedure code 97140, July 20, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

Procedure code 97140, July 25, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

Procedure code 97140, July 27, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $37.47. Therefore, this amount is recommended.

The Division finds that the requestor is entitled to a total recommended reimbursement amount of $449.64.

4. Review of the submitted documentation finds that the requestor is entitled to a total recommended amount of $449.64. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $449.64.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $449.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 10, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.